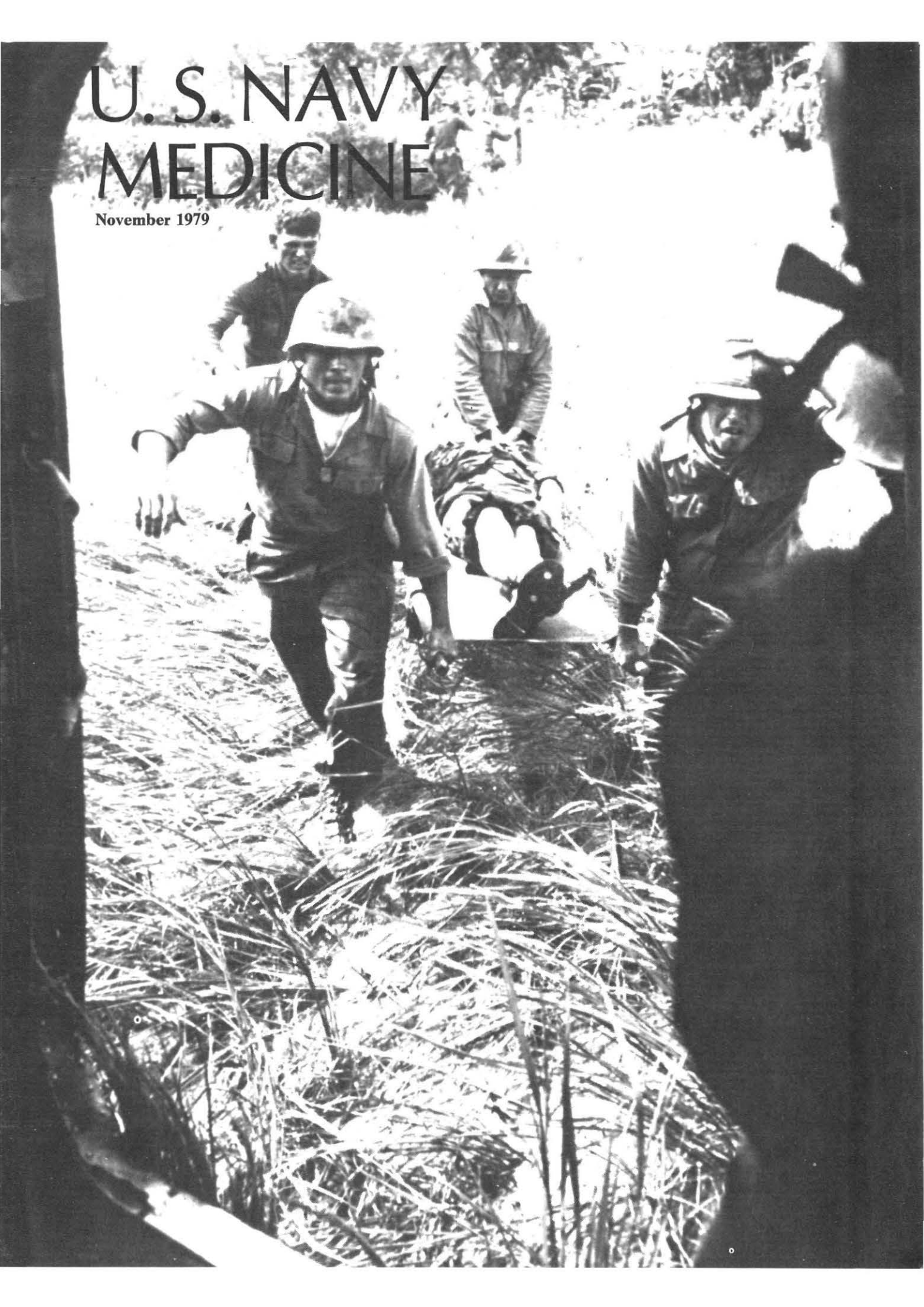


U.S. NAVY MEDICINE

November 1979



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COVER: A wounded Marine is rushed aboard a Medivac helicopter. Speedy evacuation from the battlefields of Southeast Asia saved countless lives by shortening the interval between injury and treatment. In periodic field exercises, Navy hospital corpsmen continue to hone their skills for the time they may again be needed. Story on p. 4.

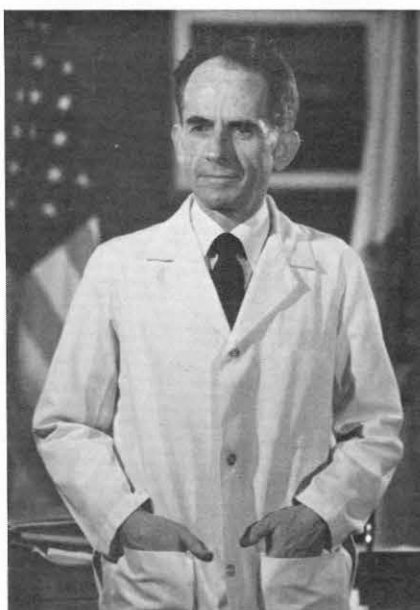
The Role of Occupational Medicine: Everyone's Concern

How often we overlook the obvious! How frequently we accept the ubiquitous as a matter of unchangeable "natural" fact. Once in a while, someone rises up to say, "No, this cannot continue! We can no longer tolerate these conditions. A more acceptable manner must be found."

In America today, the work force includes 97,401,000 people. Statistics for 1977, the most recent data published by the Bureau of Labor Statistics, show 4,760 people died as a result of work-induced or work-related reasons. An additional 5,460,300 were injured severely enough to warrant reporting.

For generations, medical people have reported their observations on work-related illnesses, and lamented the continuation of these same poor practices—practices that have exploited the worker and have either slowly or rapidly impaired the health of people. As chemistry and other disciplines have become more sophisticated, we have introduced into the worker's world, materials and processes which have created additional sources of health impairment.

Today's Navy is no exception. We utilize many of these complex materials and processes. Often, physical changes which result are largely irreversible by the time of



first observation. This is true in the changes seen from exposures to asbestos, mercury, manganese, and lead to cite just a few. Along with our counterparts in the private sector, we must continue to strive for the prevention of all occupationally-related health insults to people, ashore and afloat.


The Medical Department must provide activity commanders with advice and recommendations on how to improve and maintain satisfactory working conditions. Medical and administrative processes for selection and surveillance of per-

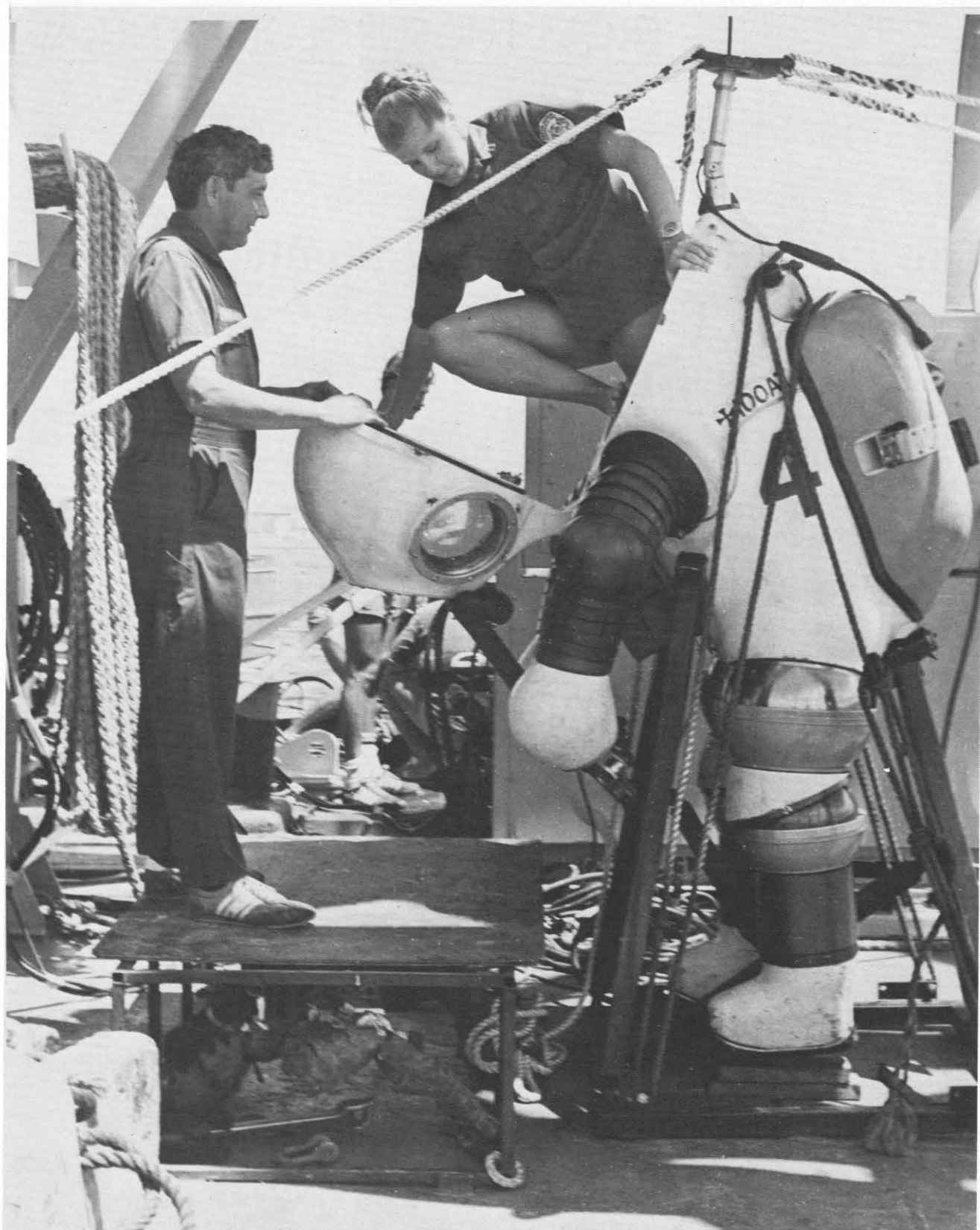
sonnel must be refined and implemented at all Navy activities and in all operating units.

Our occupational health professionals are dedicated to these ends. We have an occupational health staff in the Navy which is outstanding in quality and motivation, if not yet great enough in numbers. All of the Navy is aware of the need to alter these potentially injurious conditions and to assure, by frequent observation, that present controls are adequate and that new hazards are not introduced.

A progressively larger portion of our resources is being committed to this growing area of Medical Department service, and this is inevitable as we recognize more and more the support we must provide the line organizations, both the obviously industrial and the operating units.

We must provide all the guidance and support possible so that the Navy will function in as safe and healthful a work environment as is currently possible.


W.P. ARENTZEN
Vice Admiral, Medical Corps
United States Navy



LT Linda Hubbell, a Navy Reservist on active duty with HCU-1, climbs into Jim as Petty Officer Cross stands by to assist.

DEPARTMENT ROUNDS

The Diver's Friend

At Pearl Harbor, the Navy recently tested what diving experts say could be the greatest breakthrough in deep-sea diving to date.

The National Naval Medical Center, Bethesda, Md., in cooperation with the British company DHB Construction, lent Jim to the Pearl Harbor based Harbor Clearance Unit-One (HCU-1).

Jim is a one-atmosphere armored diving system which comes in the form of a huge, hollow magnesium alloy body. The system weighs between 1,100 and 1,200 pounds on the surface with an operator inside. Below the surface, depending on the bottom conditions, Jim weighs around 60 pounds.

A member of the team which traveled to Hawaii from the mainland with Jim, Sonar Technician First Class Carl Cross, says the project represents "physiological research."

"This testing is to find out what the divers do on the bottom, and how they operate by testing different work loads under different water temperatures," he says.

With its hinged dome head, the system looks like something from another world. Four eye-like windows in the dome, two in front angling up and down, and one angling off each side, enable the diver to look in almost all directions.

Jim also has moveable limbs. The joints are O-ringed and circular in shape, preventing the metal monster from freezing up even at its maximum diving depth of 1,500 feet.

The arms have mechanical manipulators, which are clamp-like

hands flexible enough to pick up a dime. Cross says there are different types of manipulators, "adapted to a particular job or whatever task that has to be done."

The legs, also flexible, permit Jim to walk at a 45-degree angle, negotiate steps, and bend at the waist at an angle parallel to the bottom.



Jim is a one-atmosphere armored diving system on loan to the Navy.

A set of spacers just above the boots can be changed to accommodate different operator heights. The six-foot, six-inch apparatus can be operated by a diver as tall as six feet, two inches and weighing 215 pounds or as short as five-foot, six inches.

Depending upon the weight of the diver, Jim can ascend at rates of 100 feet per minute from the ocean floor.

The one-atmosphere system is temperature controlled, protecting

the diver from freezing by warming up and stabilizing his environment at 66° to 70° F. Once, Jim dove 905 feet into the Canadian Arctic Ocean through 16 feet of ice and 27-degree water. During this series of dives Jim broke the record for the longest working dive, five hours and 59 minutes, without any discomfort to his operator.

Jim's main purpose and advantage is the elimination of decompression—preventing air embolism, commonly known as the bends.

Other added advantages include extended diving time, permitting operators to stay down for as long as 27 hours breathing their own recycled air, reduced biochemical problems, and increased capability for repetitive dives.

The concept of a system such as Jim goes back several centuries. Successful systems were developed and tested between the first and second world wars, but interest faded during the middle of World War II.

In 1969 DHB Construction was formed to reexamine previously encountered problems in deep-sea diving. This investigation resulted in a renewal of interest and the engineering of Jim.

The officer in charge of the project here, LT Bill Nelson, NNMC, says Jim got its name from a man who helped design the system, Jim Harris. Harris was also the system's primary operator.

If the tests made with Jim prove successful, the system could find itself diving for the Navy. Meantime, the huge, space-like creature seen diving to the ocean floor off Hawaii is no cause for alarm.

It's only Jim, the diver's friend.

—Story by JO3 Rick Johnson, USN. Photos by PH2 Matthew Sapanara, Jr., USN

“Corpsman!”

Making its way through thick brush, a patrol of approximately 30 Marines, on a search and destroy mission, is suddenly ambushed. Amidst the confusion of the ensuing fire fight, a wounded Marine cries, “Corpsman—Corpsman.” Two Navy hospital corpsmen assigned to the patrol rush to his aid.

With the sounds of small arms fire ringing in their ears, the two corpsmen make their way from one fallen Marine to another administering emergency treatment. The rifle fire subsides to a few scattered shots but not before taking a toll. Four Marines are seriously injured and two more sustain minor wounds.

The squad’s leading corpsman, HM1 Howard Koontz, moves methodically from one victim to another checking vital signs and dressing wounds. He prepares each casualty for transport to the Medical Battalion Field Hospital.

The radioman calls for a medical evacuation helicopter to meet the battered unit at a nearby landing zone (LZ). “This is 2nd MARDIV calling Medical Detachment 247. Meet us at LZ ‘Victor,’ I repeat LZ ‘Victor.’ We have four on stretchers and two walking.” The radio transmission is acknowledged but breaks up before any further information can be given. The Medivac crew, however, has received the most important information—where to meet the unit and the number of casualties.

Meanwhile, the fighting ends and the enemy withdraws. Combat-weary Marines, under Koontz’ direction assist in loading their wounded comrades on stretchers and moving them to the low underbrush at the edge of the landing zone, a small clearing in the jungle-

like terrain near where the ambush took place.

A helicopter breaks the calm of the warm fall day as it appears over the trees to the east and sets down in the clearing. A crew chief and medical technician open the doors as the first stretcher is rushed alongside and a wounded Marine is hoisted into the helicopter’s belly. The procedure is repeated three more times. The walking wounded are then strapped into jump seats, the doors are closed, and the copter lifts off for the field hospital.

Once there, the wounded are removed and taken inside the treatment tent under the direction of HMCM John Onorato and HMCS Harry Cave. Attached medical tags tell the doctors and nurses the nature of the injuries and what has already been done. The tags also help identify the more seriously wounded and the order of treatment.

Although this scene was a drill, the real thing occurred often enough in Korea and Vietnam. For Naval Reserve 2nd Marine Division Medical Detachment A 206, lead by CDR David Kingsbury, MC, USN, and assigned to the Naval Reserve

Center Baltimore, this was part of a simulated training exercise at Fort Meade, Md.

“This exercise is the culmination of five months planning by our unit,” said HMCM Onorato. “Many of our corpsmen have no actual combat experience,” added his colleague HMCS Cave. “They’re good people though. This exercise helps our unit learn how to work with Medivac helicopters and the pressure of being under fire. If the time ever comes that we’re called on we’ll be ready.” Cave earned his field Medical Technician NEC 8404 under fire in Vietnam.

The 21 corpsmen assigned to the unit are working toward earning the Field Medical Technician NEC 8404. Three corpsmen have earned this designation since joining the unit.

All members of 2nd MARDIV 206 work in some aspect of medicine as civilians. Their occupations range from hospital administrators and medical technicians to doctors and nurses.

—Story by JO1 Rich Beth, USN. Photos by JO1 Rich Beth, USN and JOSN Brian Curtice, USN



Wounded are placed on stretcher racks in Medivac helicopter.

Recent Publications by Navy Authors

Ambulatory Surgery for Pilonidal Disease by CDR Henry M. Meinecke, MC, USN. *American Surgeon* 45(6):360-363, June 1979.

The Grand Biopsy for the "Cold" Thyroid Nodule by CAPT Fred J. Stucker, MC, USN, LCDR Arthur B. Lacher, MC, USNR, and LCDR Ronald H. Hirokawa, MC, USN. *Laryngoscope* Sept 1979.

Summer Health Fair—Filling the Gap by LTJG Daniel A. Wilbur, MSC, USNR. *Forum On Medicine* May 1979.

The Epidemiology of Human Pediculosis in Ethiopia by CDR L.L. Sholdt, MSC, USN, HMC M.L. Holloway, USN, and Dr. W.D. Fronk. Special Publication of the Navy Disease Vector Ecology and Control Center, Jacksonville, Fla., 1979.

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The Solubility of Hydrogen Cyanide in Water by Rodkey FL and Robertson RF. *Journal of Combustion Toxicology* 6:44-47, 1979.

Defective Transient Endogenous Spleen Colony Formation in SI/SID Mice by Wiktor-Jedrzejczak, McKee A, Ahmed A, Sell KW, and Sharkis SJ. *Journal of Cellular Physiology* 99:31-36, 1979.

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Microwave Radiation and Chlordiazepoxide: Synergistic Effects on Fixed-Interval Behavior by Thomas JR, Burch LS, and Yeandle SS. *Science* 203: 1357-1358, 1979.

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An Explanation of Impaired Solute Mixing in Extracellular Fluid after Hemorrhagic Hypotension by Small A and Homer LD. *American Journal of Physiology* 236(3):H440-H446, 1979.

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Endotoxin Lethality and Tolerance in Mice: Analysis with the B-Lymphocyte—Defective CBA/N Strain by Zaldivar NM and Scher I. *Infection and Immunity* 24(1):127-131, 1979.

Different Marrow Cell Number Requirements for the Haemopoietic Colony Formation and the Cure of the W/WV Anemia by Wiktor-Jedrzejczak, Sharkis SJ, Szczylik C, Ahmed A, and Gornas P. *Experientia* 35(4):546-547, 1979.

Endoscopy as an Aid to Endodontic Diagnosis by Detsch SG, Cunningham WT, and Langloss JM. *Journal of Endodontics* 5(2):61-62, 1979.

Lymphocyte Binding and T Cell Mitogenic Properties of Group A Streptococcal Lipoteichoic Acid by Beachey EH, Ahmed A, Dale JB, Simpson WA, Grebe S, and Ofek I. *Journal of Immunology* 122(1):189-195, 1979.

Changes in Surface Immunoglobulin Isotypes on Purified Antigen-Binding Cells after Antigenic Stimulation by Kenny JJ, Ashman RF, Kessler SW, Scher I, and Ahmed A. *Journal of Immunology* 122 (5):2037-2044, 1979.

Computer Model for Simulation of Emergency Medical Systems by Fletcher JF and Delfosse C. *Military Medicine* 144(4):231-235, 1979.

Specificity of Primed LD Typing: The Major Reactions by Hartzman RJ, Johnson AH, Sell KW, Amos DB, Ward F, Pappas F, and Romano PJ. *Transplantation Proceedings* 11(1):690-695, 1979.

SPECIAL REPORT

The Surgeon General's 11th Annual Specialties Advisory Conference and Committees' Meeting

The conference was held 10-14 September 1979 in Bethesda, Md. Following is a report of the first plenary session of this annual conference.

This report represents an edited (sometimes paraphrased or abbreviated) version of the remarks and presentations of specified individuals. Their comments do not necessarily reflect official views of the Navy Department or the naval service at large. —Ed.

Surgeon General's Keynote Address

VADM W.P. Arentzen, MC, USN
Surgeon General of the Navy

Three years ago I addressed this convocation for the first time. The thrust of my message then was my absolute desire to support fully our operational forces and to eliminate the "two Medical Departments syndrome." I stated clearly my firm conviction that hospital-based practice including the care of dependents and retired was just as contributory to fleet readiness as anything we do from the platform of a ship's deck or an airplane.

We have made giant strides toward achieving those ends. Shortly after becoming Surgeon General, I instituted the curriculum in operational medicine which is an integral part of the GME-1 experience. Yesterday, our first operational medicine course commenced in Pensacola. I have insisted that we adhere as closely as possible to the policy of providing an operational experience for our young physicians when they complete their internships and before they re-enter the graduate education structure. As with most new things, there was initial resistance but as time has passed, general

acceptance has occurred. Interviews with many of these young men and women upon their return to various training programs has almost without exception produced the same evaluation: "I wasn't particularly looking forward to it but I enjoyed it." The relief from the tension of the internship year and the opportunity for reflection before plunging into the rigors of graduate training were very positive side benefits. We have adhered to our pledge that, everything else being equal, applicants for further training from the operational assignments receive top priority consideration. We have done that and our credibility on that point is high.

The readiness of our surgical teams has been improved and we are paying increased attention to training for combat surgery, especially burns and trauma. We have recently participated in the 3rd Marine Amphibious Force exercises in West PAC to demonstrate our augmentation capabilities and the preliminary reports indicate that everything went well.

The establishment of the abbreviated clinical residencies—the "mini-residency program"—has been another bridge uniting the operational and hospital medical communities. This is not designed to be a remedial program. Rather it is for the purpose of updating skills to facilitate career progression through the entire Medical Department field of responsibility. It has been successful but it needs to be expanded.

We have, I think, convinced the top echelon of the line Navy of our intent to support the active duty forces of the Navy and Marine Corps. Our credibility in that arena is also high. It is important that we be believed. The credibility of government with the public is a continuing issue—an issue of such importance that journalists have built reputations and have gained acclaim by the exposure of even marginal differences in public and private official rhetoric. It is no less true

within government or within the Navy. Our constituents have the right to expect us to keep our word. They have the obligation to treat us in a similar fashion.

As pleased as I am to see the progress we have made along this front, there is still much more to be done. But we have made a beginning—a large beginning—and I thank you for that.

But, we've been talking about a lot of other things for the past three years. How have we done in relation to those other problems? The report is a mixed one.

Our shortfall in physicians is considerably diminished. By the end of this month we hope to have brought on board 200 new physician volunteers this year—the best year we've ever had. Equally heartening is the fact that the quality of these volunteers is so good. As the output of physicians in the United States continues to enlarge, I expect to see this trend continue. We expect to be about 54 physicians short as the new year begins. I fully expect that deficit to completely disappear within the next year. Retention is up, volunteers are up, and the output from the scholarship program continues to increase. Our scholarship program again is filled; almost 1,000 applications were received for 433 billets.

We will defer more students this year for full training in the civilian sector. By the time SAC XII convenes we should be fully implementing our in-house Berry Plan. If there is one project I would like to be remembered for, it is this one. The input from civilian training programs is a key element in maintaining our excellence. Inbreeding is fatal to medical institutions. There is more than one way to do things. We should be constantly challenged by new ideas, stimulated by fresh viewpoints. We need to cherish our iconoclasts, not destroy them.

Our recruitment of dentists is going very well and we are at our authorized strength despite the loss of the dental scholarship program. The loss of that program continues to disturb me. We will be watching what happens to recruiting in this community very closely.

Nurse Corps recruiting has never been a real problem but authorized numbers have been. The problem will increase as the role of nursing expands. Anesthetists and nurse practitioners of all sorts are serving as physician extenders, but these individuals reduce the available numbers to provide hands on nursing care. It is my hope that a rational staffing plan based at least in part on a patient classification system can help us determine the real numbers we need system-wide.

The Medical Service Corps continues to be healthy with a few exceptions. We have our first uniformed audiologists on board now and will shortly have our first wave of uniformed social workers. These newest mem-

bers of the MSC family will be of tremendous benefit to us as we intensify our efforts in hearing conservation and family advocacy.

We have recently reopened our physician's assistant training program. The first 45 selectees are in training at Portsmouth and San Diego. We are attempting to obtain an additional 235 PA billets. We know that PA's are valuable members of our health care team; they help us meet the overwhelming demand for ambulatory care. We have recently assigned 12 PA's to carriers. This is a new role for the PA, one in which the PA can help us improve our service to the line Navy. I ask each of you here to take a personal interest in PA training. It is not just the other man's job—it is everyone's job to insure that we provide the best training possible to all our young professionals.

The poorest news is in the Hospital Corps. I didn't have to tell you, did I? This was a problem when I became Surgeon General. It remains one and perhaps has become a more serious one. We have managed to cope, one way or another, with all our other problems, money, physicians, etc. But this one will defeat us if not solved. Because of decreased recruiting Navy-wide, we are not filling the seats in "A" School. And that is our pipeline. The impact of that circumstance is beginning to be felt in the "C" Schools with more empty seats and higher attrition rates. We are dangerously close to the outer limits of coping. We are so short of radiology technicians that our capability to train new ones is being compromised.

Pharmacy technicians are at 85 percent of allowance. The reason we are not at the full strength at this time is because the field is converting more billets to pharmacy techs which is, of course, a catch-22. We have less quad O's. Also, there is now a market for pharmacy techs on the outside. If we retain what we have this year we will be at 100 percent of manning with the present people in the pipeline.

General duty hospital corpsmen are no more available than the others because so many have been converted into tech billets.

OR techs are at full allowance. We actually have an excess. Clinical techs are in excess. Basic lab techs are at strength. Advanced lab techs are short because this past year 170 new billets were created.

The CO's are now calling and saying, "I can do without more doctors; send me corpsmen." Without sufficient ancillary personnel, the efficiency and productivity of our physicians is much less than optimal. These young men and women work their hearts out for us but we can't stretch them beyond endurance. No staffing study done by SHORESTAMPS (Shore Requirements Standards and Manpower Planning Sys-

tems) or any other group has found that we were overstaffed with corpsmen in any NEC. I have lost my patience. Do we *have* to discover America every October?

We have had some success with equipment purchases since my first address to this conference. More money for major equipment has been available. It has not been sufficient to wipe out our backlog but it has kept us afloat and we have made a large dent in the backlog. I expect we'll continue at about the same level of funding next year. I realize that telling your staff they're going to get a piece of equipment in 1981 instead of 1983 doesn't mean much when they need it in 1979. I know that doesn't draw a round of applause, but the real world is closing in, closing in on us and the civilian institutions as well.

I should have said the *future* is closing in on us. Whether we like it or not, medical care in the United States is about as large as it's going to get. Because of the high cost, national health insurance is still way down the road but steady pressure toward a complete reorientation of health care priorities will be with us.

America is now spending more than \$200 billion a year on health care. Only a small proportion of that is devoted explicitly to the prevention of disease and premature deaths. The notable decline in deaths from heart attacks in the last 10 years is attributable not only to improvements in medical technology and treatment but also to the fact that more people are taking better care of themselves. Evidence is mounting that in modern societies continued growth in medical care—more physicians, more nurses, more hospitals and the like—probably leads to only a marginal betterment in the overall health of the general population. People who live in areas where there are a lot of doctors seem to be neither more nor less healthy than people who live in areas where doctors are scarce. Ready access to medical care while desirable does not appear to be as significant as once assumed in determining the state of health. It may be that health may depend more now on nontraditional medical considerations than on the quantity of medical care available.

Recently, the *Los Angeles Times* stated editorially what is likely to be the thrust of the future. What the individual does to and for himself almost certainly is the key determinant in health. Prevention of illness thus becomes to a great extent a matter of choice. What and how much a person eats or drinks or smokes, what care is taken driving a car, the amount of exercise taken—all influence the state of health. The most recent U.S. Surgeon General's report calls for a "second public health revolution" to improve the Nation's health.

The success of this revolution will depend primarily on education and self-control rather than on massive

new expenditures for medical technology and treatment. Now is the time to think in innovative, sweeping ways. Perhaps without our fully recognizing it, the rules of the game have changed. Our present structure works very well when there are plenty of resources to go around, enough so that even the losers get something. We can no longer depend on that occurring. This new revolution recognizes our present and defines our future.

The Federal health agencies will most assuredly lead the way in this revolution. Indeed the shock troops are already on the march. Tri-service regionalization and Federal resource sharing are already underway. State legislatures that face escalating health budgets are more frequently mandating the same sharing through health systems agencies and professional standards review organizations. While convenience is occasionally a casualty of these sharing activities, there are advantages as well, very real advantages in many instances, particularly for those of you in this audience.

The vast majority of university medical centers are dependent on public funds. They are beginning to be affected by this "revolution" now. I have encouraged you to strengthen your university affiliations to maintain excellence in our training programs, to provide us with the needed teachers until increased retention and our in-house deferment plan begins to fill the gap. The variety and size of our patient mix has always been the major attraction for academic institutions in establishing these affiliations. Now our facilities themselves are an attraction as well. Perhaps we have a full body CT scanner and the nearby university hospital does not. Perhaps the local VA hospital does not have a linear accelerator. We will be installing several next year. Increasing interdependence will strengthen these affiliations. Exploratory talks have begun in some of our institutions which could lead to fully integrated residency and fellowship programs. I urge you to take advantage of these opportunities and exploit them. Increased quality of care and excellence of training will be the result.

Because our focus of attention is human life, we are, therefore, highly visible. Escalating costs combined with this visibility forces us to be accountable to friends and critics alike. This scrutiny is unavoidable. Since it is unavoidable we must turn it to our advantage.

We must use our GME billets as the national resource they are. As the number of U.S. medical school graduates continues to increase, the number of GME positions does not. When the number of graduates exceeds the available positions, the three services' 3,500 training billets will put us in a sellers' market. The escalating costs of medical school tuition will keep our

scholarship programs fully subscribed. Increased deferments will eventually swell the ranks of our teachers and subspecialists. If I had a solution for the ancillary personnel shortage, I would feel that the millennium had arrived. But if I must, I'll take my millennium in small pieces, one breakthrough at a time.

I have heard it said that no one is smart enough to be a pessimist. I agree. I *know* there's a pony somewhere.

Despite the irritations and the frustrations, despite the inertia and the obstructionism, we have, on occasion, been able to confound our critics and show real overall progress. The reason, of course, is you and all your colleagues in the Medical Department, in every corps and in every job.

I am proud of you. Be proud of yourselves. You are members of a privileged profession, serving in a proud tradition. In a time when caring seems so transient, connections so fragile, commitment so temporary, you remain steadfast. It is a singular honor to lead you.

Current Status of Medical Department Manpower

RADM Melvin Museles, MC, USN
Assistant Chief for Professional Development
BUMED MED 02

I want to welcome you all to SAC 11 from my new position as MED 02. As many of you recall, I was intimately involved in SAC during the early 70's when I was in the training branch here in BUMED before HSETC was developed. Following that experience I spent three years with USUHS, two years as commanding officer of NRMJ Jacksonville, and the last year as Medical I.G., having had the opportunity to inspect some 15 of our hospitals and medical regions worldwide. I feel confident that these experiences have given me the knowledge and ability to fulfill my new responsibilities. I also have come into this new code with renewed enthusiasm and a positive spirit recognizing that most of our problems are people problems. You are our people, you are the products of our health care system, you are our leaders, and you represent many of our accomplishments. You also are our future. I pledge my office and my staff to provide you the necessary guidance and to do what we can to provide quality staffing for all of our medical facilities so that we can continue to offer quality health care to all of our beneficiaries.

Before I go on to discuss some specific manpower

issues with you, I would like to quickly review MED 02 now that the BUMED reorganization has become a reality.

I have been in my position too short a time to develop a full perspective and a full set of goals and objectives. However, my primary goal is to provide full support for our operational commitments and at the same time fully support our training programs. This has been the goal of our Surgeon General and he has my assurance that this will continue. The success of this effort is vital to the viability and future of our entire health care system.

I believe we are making significant progress in the reality of our commitment to the operational mission. All members of the Navy Medical Department are beginning to recognize and appreciate their dual roles as military medical specialists and as clinical or administrative specialists. All medical education programs and work experiences are now addressing themselves to readiness. The training and education experiences in peacetime must prepare us for the practice of medicine in all environments and in contingency situations. As you all know our current training programs are not adequate to meet all contingency needs. However, we are constantly moving closer to that end as we continually review our requirements and tailor educational programs to meet them.

This past year more of our new accessions came through the military indoctrination course at Newport. Ultimately our goal is to have all new Medical Department officers come through that program.

We have implemented the advanced health policy and planning course (AHPPC) for senior Navy Medical Department officers. This course was given three times this year and it has been extremely successful. The course is specifically oriented toward operational support, contingency planning, and the context in which high level leadership is exercised. We have continued the executive medicine course for mid-career officers and just yesterday we began our new seven-week operational medicine course for more junior officers who are expected to fill operational assignments. This course is being given in Pensacola at NAMI and will emphasize field medicine, preventive/occupational health, physical fitness, and combat medicine.

Last year 75 percent of our GME-1 graduates were assigned a utilization tour. I like to look upon that year as a continuation of their educational experience, a significant part of the Navy Medical Department's continuum of medical education, before they complete their own individual specialty training.

I would ask all of you again in positions of leadership to embrace this philosophy. I want you to encourage your younger physicians to consider a tour of duty with



RADM Museles



CAPT Carr



CDR Mohler (Ret.)

the operational forces. I personally feel that this should be considered as an additional educational opportunity which augments their own specialty training. The young physician, either after his GME-1 year or after his specialty training will not only be well prepared to manage the varied clinical problems that come along but will be challenged in other areas.

The Navy medical officer who is assigned shipboard duty must learn about a very unique and complex environmental situation. He must become knowledgeable and conversant with preventive medicine, shipboard sanitation, control of physical and toxic hazards, environmental pollution abatement, and many other similar problems broadly categorized as occupational medicine which will tax his ingenuity and send him to the medical literature for solutions.

Navy-wide programs concerning weight control, sight and hearing conservation, asbestos exposure, heat stress, tobacco, drug and alcohol abuse, and proper maintenance of health records are also integral parts of the medical officers' responsibilities to his command.

The Navy medical officer today should be an expert in providing medical support for any situation requiring combat casualty management or chemical, biological, or radiological warfare defense whether he has duty aboard ship or not.

The medical officer assigned to the operational forces develops a bond of friendship with his fellow officers

and men that is unequalled in civilian life. He has a wonderful opportunity to become acquainted with line officers who are as dedicated to their profession as we are to ours. They strive for excellence as we do. We must get our Navy medical officers to broaden their horizons beyond medicine by talking their language with them. They are as proud of their titles as we are of ours. They are dedicated to our country in every respect; let's increase our visibility and truly become an essential part of the backbone of our great Navy. Let's be proud of the part we play in the defense of our great country.

We continue to have excellent feedback from our operationally deployed medical officers and they will lend credence to our efforts to help solve this highly visible problem. With your assistance we can turn this around to work to our advantage.

Statistics

John Carr will go into more detail with his manpower charts but generally speaking we have every reason to be optimistic about the future.

Next year we will have 280 primary care medical officers in operational/utilization billets. That number is our commitment to the fleet and the Marine Corps.

Total GME billets authorized 980, with 1,075 actually on board. We hope to place 260 medical officers into residency training.

This year 433 scholarship students have been ac-

cepted from over 830 applicants and they are really high quality; 256 will be placed in Navy internships. This bodes well for the future. Next year USUHS graduates its first class of 30 students. Approximately one-third of those are Navy students.

Family practice continues to be one of our priorities. We have 120 family practitioners on board with a goal of 280. We have increased our training slots to 76. We are still looking forward to Bremerton as another family practice training hospital.

We are planning to start two residency training programs in emergency medicine. We need your input on this issue during your deliberations this week to assist us in developing our requirements. During my year as Inspector General I had numerous opportunities to discuss many of the issues having a negative impact on retention of our physicians. Duty in the emergency room by our specialists is another one of the key reasons many leave military service. We must train our own emergency room specialists or recruit those that are trained. Another option is to contract emergency room services but this would be prohibitively expensive.

We have two PA training programs going again, one at NSHS Portsmouth, Va., and one at NSHS San Diego. The course is 20 weeks didactic and 32 weeks practical. We have 45 candidates in training now and for FY 80 we will have 50 more. Graduates are eligible for appointment to W-2 upon graduation.

For the first time this year we have recruited 10 PA's from civilian life. Also, for the first time, we have assigned PA's to our carriers. All 12 carriers will have one PA assigned. We continue to seek other operational areas that can utilize their experience. Our PA's and nurse practitioners continue to be important additions to our health care team.

Recruiting has gone particularly well this year. Quality has markedly improved. We have gone from 55 percent foreign medical graduates to 10 percent. We had a goal this year of 276 and we have recruited 200 to date. We expect to be about 54 physicians short of authorized end strength on 1 October.

Despite our encouraging numbers, the mix and distribution of our clinical specialties remain serious problems. We continue to have serious shortfalls in orthopedics, radiology, general surgery, flight surgeons, and to a lesser extent in neurology, urology, eye, and ENT. We must improve our retention as well as our recruiting efforts, particularly in these areas.

We expected to have good news for you about variable incentive pay by this conference, but congressional delays have prevented a new bill from being implemented by 1 October.

Lack of ancillary help which all hospitals have experienced and which is a source of adverse comments from our physicians continues to get attention. We still have not solved this problem, but we are working on it.

Nurse Corps

Manning of the Nurse Corps has remained at or near authorized strength during the past several years. Recruitment of qualified applicants has been excellent. Of the nearly 2,600 officers on active duty, 25 percent are male, 75 percent are female; 24 percent of the female officers are married and 5 percent have children; 83 percent of the male officers are married and 62 percent have children. The demand for professional nursing care has been constantly growing due in part to increasing sophistication of medical capabilities. Care of acutely ill patients requires concentrated didactic preparation and expert technical skills. As length of hospitalization decreases for most patients, the degree of illness and average nursing-care-hour requirements increases. Other factors influencing the demand for nurses include the move from open bay wards to private and semi-private rooms, the replacement of the ward medical officer with physician teams, and more emphasis on preventive medicine and health maintenance. Expanded roles for nurses reduce the available billets and time for direct patient care on the staff nurse level. Approximately 152 nurses are assigned as practitioners, anesthetists, and chronic illness clinicians. Another problem is the reality that newly assigned Nurse Corps officers right out of school require prolonged orientation programs in basic skills. Retention of Nurse Corps officers is good despite co-location problems, increased numbers of dependents, pressures for more education, and some better opportunities in the civilian sector.

Medical Service Corps

This past year, under CAPT Nelson, has been one of inventory, of taking stock. CAPT Cherry Hatten, as deputy for Health Care and Sciences, and CAPT Vic Swindall, deputy of Health Care Administration have each been responsible for about 50 percent of MSC officers. CAPT Roy Tandy will relieve Vic Swindall on 1 October. CAPT Nelson's top priority issue for the MSC in FY 80 is to develop career planning models for all specialties. All MSC officers will meet the requirements of our mission under standard and contingency conditions of operation. This has been a productive year. They have more billets to fill than last year due to expansion of such services as clinical psychology, pharmacy, and medical technology. We are now recruiting

for clinical audiology and social work. The requirement for clinical social services has continued to increase in naval medical facilities with the expansion of substance abuse, family advocacy programs, and endeavors to decrease length of stay. Social service support has been an item of special interest to our present Surgeon General and is in keeping with CNO's emphasis on retention, morale, and family services. Program authorization for MSC to include the subspecialty of social workers has been approved by the Naval Military Personnel Command and authority has been granted to recruit 13 social workers. Compensation has been provided from other MSC specialties.

Overall we will have 1,850 officers on board by 1 October, 60 percent of whom are in patient care activities. We continue to increase emphasis on billets which directly support the fleet especially in the specialties related to preventive, occupational, and industrial medicine. MSC officers serve in approximately 250 different commands. In more than 20 they serve as commanding officers. In more than 40 they serve as officer-in-charge. The health of the Medical Service Corps appears sound at this time.

Hospital Corps

The Hospital Corps has a current authorized allowance of 23,176, which is presently manned at 22,271. The current measure for manning levels is based on contingency requirements. Even with a reserve HM population of 20,677 personnel, we will fall well short of contingency commitments, should mobilization take place. "Nifty Nugget" revealed a definite weakness in the Hospital Corps' ability to augment the operating forces. We were unable quickly to identify enlisted assets and mobilize them.

There is a most definite need for a total billet realignment of Hospital Corps personnel. We must consider the needs of the Navy, commands, and the members. By the proper use of our resources, we will increase the authority and job satisfaction of all senior and junior personnel. What are the true needs?

The development of a career pattern would establish the foundation for a master plan for management of our personnel. It would also result in maximized utilization and cost effectiveness for all concerned.

Overall retention thus far in the Hospital Corps is 45.5 percent. However, this is a very deceptive overall figure. The breakdown is as follows: first term, 29 percent; second term, 57.7 percent; third term, 83.7 percent, and subsequent terms, 98.5 percent retention. Retention will also be improved considerably by the institution of career patterns and proper utilization. Along with remaining senior petty officers, it is im-

portant also to reduce the loss of the first term personnel.

Women are no longer restricted to CONUS and shore duty. In compliance with equal opportunity programs, Navy noncombatant billets are not labeled male or female. At present, 10 women of the Hospital Corps are serving aboard ships. The overall advancement picture of the women is interesting and should be of concern:

Female: E-9 (0), E-8 (2), E-7 (27), E-6 (117)

Male: E-9 (176), E-8 (407), E-7 (1,717), E-6 (2,873)

The Hospital Corps has over the past few years been successful in its training programs. Formal programs are utilized for the training of hospital corpsmen in the basic school and also in over 34 different NEC's. There is considerable concern over the recent graduates of Hospital Corps "A" School, and their lack of training and/or experience. The current review of the NOTAPS (Naval Occupational Task Analysis Program) study of HM "A" School is expected to reveal our weaknesses in this area. Many changes have taken place in our "C" School community and we are making considerable headway.

Supervisory program in health resources management is a four-week course which provides training at NSHS Bethesda, Md., to better prepare HM/DT E-8/9's to assume health resources management roles often filled by junior MSC officers (40-48 quotas/yr.).

Health care administration course provides nine months of training at NSHS Bethesda, Md., to prepare HM/DT E-8/9's for assignment to management level positions at major medical centers and medical staffs of major commands (6 quotas/yr.).

Medical Corps Status Report

CAPT John E. Carr, MC, USN

Director, Medical Corps

BUMED MED 21

At the closing plenary session of SAC X we addressed several very serious problems concerning Medical Corps manpower. The shortage of orthopedic surgeons and medical subspecialists was discussed in depth. We noted that approximately 650 of our 3,400 physicians were eligible to either resign or retire during this summer and fall of 1979. That *if* we retained 100 of those 650 we would break even and stay at the same level of physician shortage, i.e., a deficit of 200. That *if* each one of you return to your respective hospitals and

worked hard at recruitment and retention, we could appreciably improve our position. And that is exactly what you did and the results have been most encouraging. Active duty extensions have been high. Recruiting has had its best year and noteworthy is the quality of applicants. Our scholarship program is fully subscribed and our first USUHS graduates will be joining us next summer. And we have put more physicians in training while supporting our operational forces better than at any time in the past five years. Let me review the statistics with you.

Table 1 is a projection comparing our on-board strength at the beginning of the fiscal year to our authorized billets. Although we will be only about 54 physicians short on 1 Oct 1979, please remember that we do not have enough billets to take care of our entire beneficiary populations. And of course the specialty mix is still a significant problem.

Table 2 shows our Medical Corps grade distribution. The line is beginning to understand now why it appears we are top heavy in captains and commanders and this is not so much a problem as it used to be. They realize a modern health care system requires many specialists which necessarily means many years of training.

Table 3 shows the Medical Corps grade distribution for females. We now have 223 female physicians or 6 percent of our total force.

Although anesthesia now has improved, we are concerned over next summer and need to address that problem at this meeting. Orthopedics is our worst case and has necessitated the implementation of many innovative plans to provide coverage. We have a significant shortage of general surgeons while the surgical subspecialties are satisfactory. There is a relative shortage of urologists which we must address.

We are in fair shape in respect to all of the specialties in Table 4 except for neurology. Our ultimate goal is for 280 family physicians. Although generally we have filled the internal medicine billets, it is in the subspecialties of medicine that we still need to stress training.

We have a relative shortage in all of the specialties in Table 5. Although it appears we have an excess of OB/GYN specialists, remember we had to close six services to reach this level and in reality we have a significant deficit.

The most significant shortage in Table 6 is in flight surgery. But we have been able to fill up all of our classes now and our position is beginning to improve. For the first time, the specialty of emergency medicine is shown and should develop rapidly in the future.

As far as our recruiting efforts are concerned, we should reach a level of approximately 200 physicians by 1 Oct 1979. We have now been able to bring selected

TABLE 1. Medical Corps - Worldwide

End Fiscal Year	Authorized Billets	On-Board
1969	4404	4482
1970	4231	4529
1971	3955	4253
1972	3858	4450
1973	4173	3954
1974	4143	3403
1975	3757	3391
1976	3656	3439
TQ	3696	3628
1977	3651	3524
1978	3636	3467
1979	3625	3571

Data Projections through 30 September 1979

TABLE 2. Medical Corps Grade Distribution

Rank	2100	2105	Total
VADM	1		1
RADM	13	1	14
CAPT	379	30	409
CDR	342	145	487
LCDR	203	882	1085
LT	96	1479	1575
	1034	2537	3571

Data Projections through 30 September 1979

**TABLE 3. Medical Corps
Grade Distribution - Females**

Rank	2100	2105	Total
CAPT	1		1
CDR	6	2	8
LCDR	8	77	85
LT	2	127	129
	17	206	223

TABLE 4. Navy Medical Corps Profile by Specialty - II 1 October 1979

Specialty	Authorized Billets	Specialty Requirements	On Board	+/-
Dermatology	41	45	41	0
Family Practice	128	160	120	- 8
Internal Medicine	249	270	261	+ 12
Pathology	71	83	79	+ 8
Pediatrics	191	206	203	+ 12
Psychiatry	94	120	106	+ 12
Neurology	30	25	17	- 13

TABLE 5. Navy Medical Corps Profile by Specialty - III 1 October 1979

Specialty	Authorized Billets	Specialty Requirements	On Board	+/-
Ob/Gyn	118	120	121	+ 3
Ophthalmology	54	52	42	- 12
Otolaryngology	53	55	44	- 9
Radiology (Diag)	81	121	64	- 17
Radiology (Ther)	7	8	4	- 3
Nuclear Medicine	7	10	5	- 2
Medical Research	63	64	41	- 22

TABLE 6. Navy Medical Corps Profile by Specialty - IV 1 October 1979

Specialty	Authorized Billets	Specialty Requirements	On Board	+/-
Flight Surgery	205	290	149	- 56
Undersea Medicine	45	47	39	- 6
PCMO	446	461	506	+ 60
Prev Med (Gen/Occup)	30	38	22	- 8
Prev Med (Aero)	40	40	37	- 3
Emergency Medicine	1	64 ±	2	
GME	980	992	1075	+ 95
Students (Aviation and Submarine)	110	110	33	- 77

TABLE 7. FY 79 as of 6 September 1979

	U.S. Grad	FMG
Anesthesiology	6	4
Aviation Medicine (Flt Surg)	8	3
Cardiology	5	
Dermatology	1	
Emergency Medicine	1	
Epidemiology	1	
Family Practice	5	2
Internal Medicine	16	8
Internship	9	1
Nephrology		1
Neurology	1	
Nuclear Medicine	1	1
Obstetrics/Gynecology	5	6
Ophthalmology	3	
Orthopedic Surgery	6	1
Otorhinolaryngology	1	1
Pathology	4	1
Pediatrics	9	3
Psychiatry	8	4
Pulmonary Medicine		1
Radiology	6	6
Surgery	7	4
Thoracic Surgery	1	
Undersea Medicine	4	
Urology	2	2
General Medical Officer	15	11
Totals	125	60 = 185

physicians on active duty as commander and captain on an individual basis.

Table 7 shows the distribution of volunteer physicians by specialty. The U.S. graduates now outnumber FMG (foreign medical graduates) and it is significant that the quality of both groups is markedly improved.

Table 8 shows what happens to the AFHPSP graduate. We would like to increase NADDS (Navy Active Duty Deferments) to about 200 per year. This would provide the specialists we need to augment our training programs and to meet requirements while preventing inbreeding. This effort is known as our "Arentzen Berry Plan" and will grow each year.

We still have many significant problems to address but after reviewing this past year one cannot help but come to the conclusion that the worst is past and the future is indeed bright.

Educational Programs and Scholarships for the Naval Medical Department

CDR Clarence B. Mohler, MSC, USN (Ret.)
Head, Procurement Programs and Accessions Branch
BUMED MED 214

I would like to say a few words about internships, scholarships, and USUHS (Uniformed Services University of the Health Sciences). I would like to address these programs in perspective as they occur in the order of priority.

TABLE 8. Armed Forces Health Professional Scholarship Program

Fiscal Year Degree Received	Number of Graduates	Navy Interns	Navy Residents	Civilian Interns	NADDS Deferment
1975	300	92	45	30	133
1976	356	80	52	214	10
1977	250	172	0	49	29
1978	300	219	0	56	25
1979	296	228	0	37	31
1980	400	235	0	65	100
1981	400	200	0	50	150

First allow me to address the AFHPS (Armed Forces Health Professional Scholarship Program). I put this program first because in the all volunteer force it is and will continue to be our prime source for the procurement of professional talent.

Secondly, I would mention the USUHS. To be sure, this is a small program in comparison to the AFHPSP, but because of the motivation of the students at university, its impact upon the Medical Corps of the future is bound to be mighty. It is anticipated that the career cadre and much of our future corps leadership will come from USUHS graduates. Many of the earlier students are from the academy, the ROTC, or the active duty community. Because they chose the Navy early and because of their training, we must assume that they are motivated. Because of their service obligations (12 years, exclusive of GME for an academy graduate) we must assume that their retention rate will be superior to the rate of any other group.

Thirdly, I shall list internships. This is not because I believe GME is less important than undergraduate education but simply because nearly all our GME candidates today come from the undergraduate sponsored programs. I should like to touch on a few issues that are of concern and interest to us all. All of you are aware of the high quality of the scholarship graduates because they rotate through your commands. However, you don't know about those who leave the program and never serve.

First let me say that the programs under discussion are alive and well. We have no significant procurement problems filling all programs with outstanding candidates. However, we are dealing with humans and humans are not always predictable. In our selection process we do goof from time to time.

The attrition rate for the scholarship program is minimal. Since 1973, the program has produced nearly 2,000 doctors, not to mention dentists, psychologists, and optometrists. The number of dropouts for all causes has been about 90. This gives us an attrition rate of less than five percent. I believe you will find this compares very favorably to the overall attrition rate that applies to all students in all medical schools.

Students leave our programs for several reasons. The most significant is academic failure followed by change in motivation, sickness, death, unacceptable behavior, moral turpitude, dependency, and conscientious objection. All these are legitimate reasons for leaving the program, and as a career military officer, I can accept them without question except for conscientious objection. Almost without exception, the decision to become a conscientious objector comes at the end of the educational cycle, after all program benefits have been re-

ceived, and when the Navy has no opportunity to reverse the scholarship and obtain a doctor replacement by giving it to another worthy candidate.

What happens to the scholarship benefits? Does the dropout have to pay them back? The answer to that is yes and no. Our authority to recoup scholarship program benefits is limited to those cases where the individual fails to serve his obligation as a result of action not initiated by the government. This limits our recoupment authority to those cases mentioned in the latter categories such as dependency, moral turpitude, and conscientious objection.

Dependency, so far, has been limited to females who are pregnant or have children. Of course, here it is quite clear that the government had nothing to do with the action and the money must be paid back. However, here I might say that we have one young man who has discussed with us the possibility of a dependency discharge because he is divorced and is a single parent who has custody of a minor child. That was several months ago and so far we have not heard further from him. Moral turpitude has involved only male students who have become involved in criminal behavior and/or drug abuse.

Let me return to money for a moment. You will note that we are not reimbursed from some categories. Here we could say that the government had nothing to do with the action that caused a student to fail academically or change his motivation for medicine. Why can't we get the money back? Almost without exception, these students have informed the Navy that they wish to serve their obligations in another officer corps as required by the contract. Sometimes another corps has a need and the officer so serves. Sometimes, there is no need, so the only alternative is discharge. In this instance it is held that the action is initiated by the government because the individual volunteered and we won't take him.

The oddities that I have noted here make it appear that we are wasting our money. Nothing could be further from the truth. There are very few students who explore pathways for circumventing their obligations. The number is so small that an understandable percentage could not be calculated. By far, the medical students we are sponsoring today are red-blooded Americans who are motivated, loyal, honest, and intelligent. I can honestly say that one of the highlights of my day is when I have an opportunity to assist one of these young men or women with their transition from civilian to military life.

For internships to begin in 1980, we have 256 billets. At this time we have 340 completed applications. We have about 20 applications that may be complete before

SAC is over. I realize this number of applications, as compared to billets, does not give us an optimum in selection possibilities. It would be better if we had two candidates for every billet. However, it must be realized that these are top quality candidates. They have already been screened once in the selection process for scholarships. I am most confident that on 1 July 1980 the group of interns you will commence training will be as good as interns anywhere.

Navy Urology: A Status Report

CDR S.M. Steele, Jr., MC, USN
Chairman, Department of Urology
NRMCMC Portsmouth, Va.

This has been an encouraging SAC with respect to the quality of our urology applicants and especially regarding the numbers of physicians we are told will be coming into the system three, four, and five years down the road. This encouragement does not, however, alter the fact that Navy urology is having significant problems. Of all our difficulties, the one which is most crippling is our support personnel or, better stated, our lack of support personnel, especially urology technicians, NEC 8486. Technician staffing is painfully inadequate number-wise and the maldistribution is worse. This problem is not a new one but has been specifically addressed by Urology Committee SAC reports in 1970, '72, '77, and '78. We also recognize that the problem is not limited to urology, as the general topic of support personnel for specialized services was addressed at the closing plenary session in 1976. The significance of this problem was underlined by the participants in the Surgeon General's Graduate Medical Education Conference of January 1979 as they wrote "adequate quality and numbers of professional, technical, secretarial, and clerical support personnel" ranks as one of the four factors of paramount importance influencing decisions to make a career of the Navy.

We also have hard, objective evidence that we are understaffed and that our claims for numbers of technical and civilian personnel are justified. This documentation is found in the Work Center Staffing Standards Report published in October 1978 by the Navy Manpower and Material Analysis Center, Atlantic. We are not in 100 percent agreement with the standards but their implementation would go a long way toward easing our present situation.

Maldistribution, particularly the assignment of fully trained urology technicians to billets which provide no



CDR Steele

urological support, is the hardest aspect of our technician shortage for us to understand. The July printout for 8486's identifies 65 technicians, which is 12 less than the present number of billets. Of those 65 technicians, 11 (17 percent), one out of every six, are assigned to billets which are unrelated to urological support. Eight of these technicians are assigned to medical centers without urologists, two at Corpus Christi, two at Memphis, and four at Philadelphia. Despite telephone calls, naval messages, and assurances to the contrary, one new technician graduate was just sent from San Diego to Yokosuka, which has no urologist. Despite my efforts, a new graduate was sent to Philadelphia in July. About six months ago a technician reenlisted and was sent from Oakland to Memphis. His first set of orders was to Biloxi, Miss., which has not had a urologist in the memory of anyone on the Urology Committee. Oakland, one of our training programs that has billets for five technicians, really needs seven, but has only two on board and new graduates continue to receive orders to hospitals without urologists. We simply do not understand this.

In addition to this, our needs with regard to training and stability are becoming more acute due to the tremendous technologic advances in urology over the past five years. Training and staffing which were adequate in 1974 no longer suffice. We now have instruments and perform studies on a routine basis which were infrequently performed in investigative centers as

little as five years ago. Navy trained urology technicians undergo six months of formal training which, at our best guesstimate, costs a minimum of \$10,000 per trainee. This six months provides background and practical experience, but it takes an additional 12 months of duty before one has a really good technician. Some technicians graduate with the rate of HM2. Urology technicians lose their NEC when they are advanced to HM1. It is neither time nor cost effective to train individuals and then strip them of their NEC when they have become proficient and valuable members of the health care team. Defenses raised for this process are: What can they do on sea duty and what is their mobilization role? There are at least two solutions to these problems: Urology technicians are easily cross trained as OR technicians, many already function as OR technicians in their present billets, and some first assist in major procedures such as nephrectomies and pyeloplasties. Urology technicians are also highly skilled in urographic procedures and are readily cross trained to perform most radiographic studies. This identifies two billets which urology technicians could fill on a carrier, LKA, LPH, or similar ship or with the Fleet Marine Force. With respect to NEC, the second billet identified, 8452, the radiology technician, retains the NEC through E-7.

The foregoing provides objective evidence that our requests for staffing are well founded. We believe we have demonstrated the inefficiency (both in time and dollars) of being advanced out of NEC 8486 at the E-6 level. We have identified mobilization/sea billets which the 8486 can fill, one of which retains its NEC through E-7. We believe that retention of NEC 8486 through E-7 is justified on the basis of today's state of the art, time and cost effectiveness, and the multiple roles these technicians can fill in the event of mobilization.

We believe that the foregoing proposed solutions to our most pressing problem are feasible, workable, and realistic. We fully understand that certain numbers, billets, and assignments are regulated by policies, laws, and/or offices not subject to control by BUMED. We are asking for help from BUMED and/or HSETC. Help us to initiate whatever action is needed to realign the billets so that urology technicians will not continue to be assigned to hospitals without urologists while those with urologists and even with training programs are less than 50 percent manned. Help us to initiate the action needed to retain our technician rating through E-7. Help us initiate the action needed to raise technician staffing to needed levels.

In closing I can only say that I sincerely hope one of our successors will not have to stand up here in 1985 and repeat what my predecessors and I have had to say.

Recommendation Made as Chairman of the SAC XI Operational Medicine Committee

RADM C.H. Lowery, MC, USN
Assistant Chief for Health Care Programs
BUMED MED 03

The Operational Medicine Committee recognizes the impressive emphasis which has been placed on the operational portion of Navy medical education and training continuum during the past three years. The results of these efforts are now being recognized. Applicants to graduate medical programs are demonstrating higher degrees of maturity, professional knowledge, and career orientation. Deficiencies remaining are those related to a real lack of professional medical leadership being provided to these junior medical officers during their early medical learning experiences outside the traditional medical center environment. To provide this "role model" leader, we need to place greater emphasis on the importance of expanding operational opportunities to our mid and senior grade career medical officers. This thrust, if met willingly and with an appreciation for its potentially positive impact on the professional development of our future career medical officers, will also serve to enhance the capabilities of these developing leaders for both contingency requirements and teaching contributions to the Medical Department of the future.

To paraphrase this recommendation, we believe there is a definite need to improve the quality of our medical leadership in the field of operational medicine and to provide favorable "role models" for our junior medical officers who are assigned to operational medical billets. In addition, assignments of senior grade medical officers to positions of leadership within operational medicine and their positive acceptance of their responsibilities should be considered as a means of career enhancement for our career officers.

Findings of the Otolaryngology Committee

CAPT Clarence G. Strom, MC, USN
Chief of Service, Otolaryngology
NRMC Oakland, Calif.

During the deliberations of the Otolaryngology Committee we found that we did not find, could not find out



CAPT Strom

who, where, why, and when individuals were being or had been deferred for outside training. Many of the other committees were apparently faced with the same difficulty. We feel that it is of utmost importance for these applicants to be routed through these SAC committees for consideration regarding deferment and placement. Though we agree with the Surgeon General's "Berry Plan" we feel it is folly to leave openings in Navy programs, especially when they are of such high quality and into which so much time, effort, and money have gone. To make any judgments or plans as to future needs is impossible if you don't know where these individuals are.

Secondly, the same would hold for "trained" individuals applying to the Navy for the first time or coming back into the service after a period of active duty. A few phone calls to the program chairman concerning these people would help the Bureau immensely in placement. The individuals might be good both for teaching and nonteaching positions. Also, program chairmen might have information regarding the individuals which would suggest that they not be placed in the service at all.

Thirdly, the attrition rate in otolaryngology is high. An estimate of 10 percent of persons remaining beyond their obligated time is considered optimistic. We feel that 66 otolaryngologists are required in the Navy at the present time; 43 are now on active duty with an estimated loss of 16 to 20 by July 1980; 8 will be produced by Navy residency programs, giving at the most, 30-35

on-board by FY 80, or 50 percent of required strength. Estimated manning for FY 81 and 82 are 30-40 percent at the most. Such a loss not only has ramifications on patient care throughout the Navy, but has a marked impact on specialty training programs and especially family practice training programs. Included in the potential losses within the next three years are the majority of present and potential program chairmen of the teaching programs in the Navy. As one of our committee members said, never has he had a job that he enjoyed more that paid so little compared with the responsibility that it carried. Obviously, the pay bill (the Uniformed Services Health Professionals Special Pay Act of 1979) is of extreme importance.

Finally, I would like to say something about Naval Hospital, Oakland and I feel that the ideas are shared by other department members at Oakland.

NRMC Oakland has residency programs, program chairmen, and staff members that rank with the highest in the country and this includes the majority of the university training programs. However, as you know, rumors run rampant through interns and residents. Persistent innuendo concerning the publicity Oakland received three years ago and continued rumors concerning the closing or non-closing of Oakland Naval Hospital or Letterman Army Hospital badly affect resident and intern recruitment. We want you to know and to tell interns and residents and medical students that you interview that Oak Knoll is alive and well and not living under an assumed name in Oakland.

Protection of Human Subjects

CDR Harold M. Koenig, MC, USN
Department of Pediatrics
NRMC San Diego, Calif.

Points I am going to make today do not deal just with pediatrics. They really cover all of us who are interested in doing any kind of research that has to do with human subjects who may at the time that the research is being done be in a compromised state of mental health or ability to make decisions. The reason this has come up is because of SECNAV INSTRUCTION 3900.39A dated March 1978. I will read a portion of this instruction that pertains to our problem:

"Third party consent (i.e., that given by parents, legal guardians, next of kin, or other legally authorized third party representatives) may be used only when the prospective human subject is factually capable of giving informed consent. Persons who are not factually capable of giving informed consent shall not be used as subjects."

The term "factually capable" is not defined in the instruction, nor is there universal agreement on who or at what age one is "factually capable" of giving informed consent. The committees for Protection of Human Subjects at two of our largest naval medical centers have refused to act on any research protocols involving children since becoming aware of this instruction. The impact has thus been primarily on pediatric research, but careful scrutiny and rigid interpretation of the instruction would suggest that research cannot be conducted on any individual in an altered state of consciousness.

Clarification of how this instruction was to be interpreted by local committees for the protection of human subjects was requested from the Surgeon General. His reply was that this instruction represented "a conscious decision to limit research and clinical investigation to minors who are capable of giving informed consent" and added that "this may be an issue deserving further discussion and deliberation with a view toward modifying the instruction." The purpose of this statement is to attempt to obtain further clarification of and possibly modification of SECNAV INSTRUCTION 3900.39A.

The need for further research in children is indisputable. Without research, there is no progress. Established methods can no longer be challenged and tested by the scientific method. Without research, our training programs will become apprenticeships where mistakes are compounded by being retaught.

In 1974, Congress passed the National Research Act, establishing a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. This commission, composed of outstanding representatives from the legal, religious, scientific, and minority ethnic communities, has drafted 10 recommendations regarding the protection of children who are used as subjects of scientific research. These recommendations represent the most thoughtful analyses of the issue of protection of the rights of human subjects ever accomplished. It is anticipated that these recommendations will become law within the year.

We would like to request that the Surgeon General seek further clarification from the Secretary of the Navy as to whether or not research in children may continue within the Navy Medical Department under the present instruction and to request that the recommendations of the National Commission be adopted into the SECNAV instruction regarding the Protection of Human Subjects, so children who are subjects of biomedical and behavioral research in the Navy Medical Department are afforded the same protection that other children in this nation will receive.

QUESTION AND ANSWER SESSION

Participants answering questions from the floor:

VADM Willard P. Arentzen

RADM Almon Wilson, Commanding Officer, HSETC

RADM Frances T. Shea, Director, Nurse Corps

RADM Melvin Museles, Assistant Chief for Professional Development

CAPT Paul D. Nelson, Director, Medical Service Corps

CAPT John E. Carr, Director, Medical Corps

CDR Clarence B. Mohler, MSC (Ret.), Procurement Programs and Accessions Branch

HMCN Stephen W. Brown, Director, Hospital Corps

Q: What is the present BUMED policy on the stability of tours?

CAPT Carr: As far as the Medical Corps is concerned, the days of moving people for the sake of moving them are over. This has been the thought of the Surgeon General for some three years now. There has been increased stability. There is no doubt that places like San Diego and Bremerton are very desirable places. Where we have the problem are places like Adak, Keflavik, and Guantanamo. What we try to do is minimize the tour in places that are less desirable and maximize the tour in other places.

RADM Museles: I generally agree with that policy but we can't develop one group of people that is immovable and another group that is movable. We have to keep that in mind when we look at retention of individuals in various duty stations that are considered good assignments. We do have those duty stations that are considered less than desirable. Again, some of these are based on attitude. We may be able to improve the attitude of those going to what are perceived as less than desirable duty stations. Whether you believe it or not, some of those assignments are career enhancing. We cannot get into a position where we develop two groups of people. We certainly do encourage longer tours. It's cost effective and in many respects it meets our training needs. Yet we must continue to revitalize our training programs by moving new people in periodically.

Q: Most of us who recognize the shortage of Hospital Corps personnel are extremely concerned about it. It's been a Navy policy in the past that when there is a critical shortage in a particular element of enlisted personnel, bonus plans and other means are used to

help correct the situation. Has there been any thought to using these techniques for the Hospital Corps?

HMC Brown: Yes. We have approached the detailers and those involved with incentive programs. We realize our shortfall. Again, money is the problem. I'm looking at other ways we can improve our retention. This has been a problem for a long time, at least 10 years. Now is the time to do something about it. It's up to all of us to increase retention. We will continue to push for more incentive and education programs.

Q: In your opinion, what is the key problem in retaining corpsmen beyond their initial enlistment?

HMC Brown: It's a case of their feeling wanted and having the opportunity to advance. We have to utilize these people and give them meaningful jobs. We must train them and then use the talent we've trained.

VADM Arentzen: Let me say something about the enlisted side of the house. Navy-wide, if you take the various corps, we are in far better shape than some of the electronic technicians, bosun's mates, and so forth aboard ship. You can even say the same thing about the line officer today regarding positions. The retention rate of pilots is as low as it's ever been. The airlines are signing up more and more every year.

Our enlisted people have no upward mobility and that's been one of my goals since taking over. That's why you see HMC Brown sitting here to head the Hospital Corps. These people are smart, ambitious, they want to be trained. When I wanted to put the master chiefs into the long course here in health care administration, I was told that you don't educate an enlisted man, you train him. Well, I disagree. These men want education today and if we don't give it to them, they will get it on the outside.

In your hospitals, look around and see where corpsmen are being wasted. It's up to you to put pressure on your skippers to get those corpsmen out where they belong. You will find that although the wards are short of corpsmen, patient affairs is not short nor is the supply department short of corpsmen. Get to your COs and get them to use these people where they are needed.

Another thing that will keep them in is a "Thank you" and a pat on the back for a job well done.

Q: As our resources dwindle, there seems to be less time for physicians on the wards to devote to educating corpsmen and also taking care of patients. The training

could probably be done better in the corps schools. Perhaps the corps schools should be lengthened.

RADM Museles: I think you're right. Our corps schools need to be lengthened. We need to give them more training and experience. Higher authority has curtailed the length of training. We fought that battle in the past and will continue to fight it in the future. It is our schooling that has suffered over the years. And it's true of our medical schools as well. Our doctors need an internship now more than ever. It's true of the Nurse Corps. I think their schools have gone the same way—more education and less practical experience. When they come out, they don't have an opportunity for an internship, but they need one too and they have to create one which uses up their resources.

Our Medical Service Corps officers are coming out with masters and Ph.Ds. They get into the system and they also need experience.

I don't know the answers to all these problems but I think we have to go back and look at our education and training programs and make them more relevant to our needs.

RADM Wilson: The problem of training corpsmen has been with us for 100 years. In the old days a corpsman used to go to corps school for 16 weeks. He then went to some hospital and stayed on the ward for 6 months. Some hard-charging LCDR or nurse grabbed him when he went aboard and kept him there until he was a pretty good ward corpsman and then he moved on. It was also the day of the ward medical officer who had some interest and some time and taught the corpsman. Those days are gone.

Today we are looking at a completely different situation. The problem is how much is enough at corps school? No one can walk out of civilian life and into something as complicated as the medical world and in 8, 10, or 12 weeks get a working knowledge that will enable him to do things effectively. Therefore, no matter how long you put a corpsman in "A" school, be it 8, 10, or 16 weeks, he or she will still require some kind of supervised clinical experience before they can adequately utilize what they know.

Secondly, how much do you want them to know when they come out of "A" school? Do you want them to come out third class? Specifically, what do they need to know? We are now trying to find out what they know and to find out what customers expect them to know. I think there may have been a failure of communication between us the trainers and you the customers. We may not have communicated to you what skills they do

possess and what level of understanding we have tried to instill in them. You may be expecting too much, or we may be wrong on our end of it.

The prospect of getting an "A" school corpsman an assignment on a ward after corps school is increasingly difficult because of money. It amounts to PCS money and the fact is that the population in our hospitals is lower these days than it used to be. We don't have the inpatient load we once had to justify training all that many corpsmen for all that many weeks.

If any of you have ideas about specifics that you want "A" school corpsmen to know, I wish you would communicate your thoughts to us. We are trying desperately to get some kind of reasonable profile that represents the product of our corps schools.

Q: Once upon a time the Uniformed Services University was supposed to be that—a total university. It was to include ancillary medical fields, nursing as well as medical. It seems that if that could be organized, we would be able to train nurses and you could do it in a milieu where they could be well grounded in the military hospital system. I wondered if that concept has been totally abandoned or if there is any prospect for it in the future?

RADM Shea: The last I heard, this program had been abandoned because of the cost. The cost to put nurses

through the Uniformed Services University would be prohibitive. There are no federally funded programs at the present time for the military, except the out-service programs that we ourselves use to educate nurses. The funding of registered nurses in out-service education—that is for the civilian nurse to go to school—has been cut back radically. HEW grants have been cut and I just don't see, in the immediate future, that there will be more funds appropriated for the education of nurses.

As far as the Uniformed Services University is concerned, I don't think it would solve our problems to any great degree because the problem we have right now is not getting nurses. We can get them; we could get more than 2,600. What we need are the billets. I think what we really have to do is to look at our situation to see where our billets are—and we are doing this—and to put them where they are best needed.

This doesn't answer your question except to say that I don't think that we will be going to the Uniformed Services University. If we do, the numbers of students would be minimal, maybe 30 per each service for class. And that would be five or six years down the road. What we need are billets. Every time we add more nurse anesthesia billets or add more nurse practitioner billets, that comes out of the total pie. We just have to decide what we want and where we want to utilize them. We must work with what we have and train what we have. That's reality.

Navy Rafters Save a Life

A rafting trip turned into an unexpected real life emergency for several NRMC Oakland personnel who participated in the recent off-duty outing.

On 22 Sept 1979, Center members beached their rafts for a short rest near Coloma, Calif., after successfully negotiating "Troublemaker Rapids." They were out of the rafts and ashore when an unidentified man standing on a bridge above the river called out that he had spotted a body floating in the water. Commercial guides accompanying the group plunged into the water and pulled the victim, a woman in her early 20s, to the bank.

The guides shouted across the river to the medics for help and

physicians CDR Charles C. Spielman, LT Bonnie M. Potter, LCDR Richard R. Imes, and LT Paul Garst, together with nurses LCDR Marty Sherrard and LT Penny Turner, immediately responded, paddling by raft across the turbulent waters to begin resuscitation efforts while MSC officer LT Bruce Custis took off to notify the Park Ranger.

One of the attending Navy physicians said the victim appeared dead. "She had no pulse and no blood pressure, and of course, she had inhaled a lot of water into her lungs." Nevertheless, the Navy physicians and nurses kept up the emergency treatment for at least another 15 to 20 minutes.

Meanwhile, the Park Ranger called the California Highway Patrol, which sent paramedics and a helicopter to the scene. With the arrival of the paramedics, the Navy doctors had access to medications and a monitor, which showed that the victim had resumed breathing and established cardio-rhythm. Their resuscitation efforts had proven successful.

The young woman was placed aboard the helicopter and, with Dr. Spielman at her side, was transported to the Marshall Hospital in Placerville. The Navy cardiologist assisted emergency room physicians there until the patient was stabilized and transferred to a special care unit.

NOTES

ROSTER—1 SEPTEMBER 1979

Following is a list of staff medical and dental officers of major fleets and forces; district medical and dental officers; commanding officers; executive officers; directors of administrative services; directors of clinical services; chief nurses of Medical Department activities; division surgeons and dental officers of Marine divisions, Marine aircraft wings, and Marine brigades.

CINCPACFLT/CINCPAC (ADDU)	RADM D.E. BROWN, JR., MC, USN
CINCPACFLT	CAPT N.D. WILKIE, DC, USN (ADDU)
	AO CAPT C. WIMBERLY, MSC, USN
CINCLANTFLT/CINCLANT (ADDU)	RADM J.R. LUKAS, MC, USN
CINCLANT/CINCLANTFLT/CINCPACFLT	RADM J.B. HOLMES, DC, USN
CINCLANTFLT	AO CDR B. OZMENT, MSC, USN
SACLANT	AO CDR W. BRANSCUM, MSC, USN
CINCUSNAVEUR	CAPT A.P. BELMONT, MC, USN (ADDU)
	CAPT R.P. MORSE, DC, USN (ADDU)
COMNAVFORJAPAN	CAPT B.L. JOHNSON, MC, USN (ADDU)
	CAPT E.T. WITTE, DC, USN (ADDU)
COMNAVLOGPAC	RADM D.E. BROWN, JR., MC, USN (ADDU)
	AO CDR C.A. ROPER, MSC, USN
COMNAVAIRLANT	CAPT D.J. LETOURNEAU, MC, USN
	CAPT K.F. BATENHORST, DC, USN (ADDU)
COMNAVAIRPAC	CAPT F.E. DULLY, MC, USN
	CAPT A.L. DAVY, DC, USN (ADDU)
	AO LCDR C. SCHMUTZ, MSC, USN
COMSUBLANT	CAPT B.J. BLANKENSHIP, MC, USN
COMSUBPAC	CAPT W.C. MILROY, MC, USN
	CAPT N.D. WILKIE, DC, USN (ADDU)
CNTECHTRA (NAS MEMPHIS, TN)	CAPT C.W. BRAMLETT, MC, USN (ADDU)
	CAPT D.G. GARUER, DC, USN (ADDU)
CNATRA (NAS CORPUS CHRISTI, TX)	CAPT T.J. TRUMBLE, MC, USN (ADDU)
COMNAVSURFLANT	CAPT W.M. PHILLIPS, MC, USN
	CAPT J.P. WILLIAMS, DC, USN (ADDU)
COMNAVSURFPAC	CAPT D.C. GOOD, MC, USN
	CAPT R.E. THOMAS, DC, USN (ADDU)
	AO LCDR R.W. BARNHILL, MSC, USN
COMNAVFORCARIB/COMANTDEFCON	CAPT P.C. GREGG, MC, USN (ADDU)
	CAPT D.E. BARLOW, DC, USN (ADDU)
COMFAIRMED	CAPT J.A. MCKINNON, DC, USN (ADDU)
COMTRAWING 4	CAPT A.D. SORENSON, DC, USN (ADDU)
FOURTH NAVAL DISTRICT	DMO CAPT R.E. TOBEY, MC, USN (ADDU)
	DDO CAPT A.F. REID, DC, USN (ADDU)
	AO LT J.N. GALLIS, MSC, USN (ADDU)
NAVREGMEDCLINIC, PORTSMOUTH, NH	CO CDR D.W. REEVES, MSC, USN
	XO LCDR R. RELINSKI, MSC, USN
	SR NURSE CDR M. BRAXMAN, NC, USN

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NAVREGDENCEN, NEWPORT, RI	CO CAPT W.A. PETERSON, DC, USN DCS CAPT R.B. ANNIS, DC, USN DAS LT J.C. WANAMAKER, MSC, USN
NAVSUBMEDCEN, NEW LONDON, CT.	CO CAPT L.H. SEATON, MC, USN DCS CAPT R.B. JOHNSON, MC, USN DAS LCDR M.S. DUNY, MSC, USN CH NURSE CAPT N. LUNDQUIST, NC, USN
NAVSUBMEDRSCHLAB, NEW LONDON, CT.	CDR R.A. MARGULIES, MC, USN
NAVREGMEDCEN, PHILADELPHIA, PA.	CO CAPT R.E. TOBEY, MC, USN DCS CDR C.T. CLOUTIER, MC, USN DAS CAPT H.S. RUDOLPH, MSC, USN CH NURSE CAPT C. SHEA, NC, USN
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NAVMEDMATSUPPCOM, PHILADELPHIA, PA.	CO CAPT O. STALLINGS, MSC, USN
FIFTH NAVAL DISTRICT	DMO RADM G.E. GORSUCH, MC, USN (ADDU) DIR DENACTYS RADM J.B. HOLMES, DC, USN (ADDU)
NAVREGMEDCEN, PORTSMOUTH, VA.	CO RADM G.E. GORSUCH, MC, USN DCS CAPT J.N. RIZZI, MC, USN DAS CAPT D.E. SHULER, MSC, USN CH NURSE CAPT M.J. NIELUBOWICZ, NC, USN
NAVAL SCHOOL OF HEALTH SCIENCES DET, PORTSMOUTH, VA.	OIC CAPT B.A. MCKAY, NC, USN AO LT G. MURPHREE, MSC, USN
NAVREGDENCEN, NORFOLK, VA.	CO RADM J.B. HOLMES, DC, USN DCS CAPT A. HERR, DC, USN DAS CDR C.A. WESOLOWSKI, MSC, USN
NAVAL BASE, NORFOLK, VA.	RADM J.B. HOLMES, DC, USN (ADDU)
NAVAL OPHTHALMIC SUPPORT & TRAINING ACT, YORKTOWN, VA.	CO CAPT J.G. WILCOX, MSC, USN
NAVHOSP, CHERRY POINT, NC.	CO CAPT D.E. STILL, MSC, USN DCS CDR E.J. WOLSKI, MC, USN DAS LCDR J.W. BALDWIN, MSC, USN CH NURSE CDR H. HOLBROOK, NC, USN
NAVREGMEDCEN, CAMP LEJEUNE, NC.	CO CAPT J.L. HUGHES, MC, USN DCS CAPT R.R. PALUMBO, MC, USN DAS CDR J.E. DEWITT, MSC, USN CH NURSE CAPT E. CARSON, NC, USN
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NAVAL ENVIRONMENTAL HEALTH CENTER, NORFOLK, VA.	CO CAPT J. CARUSO, JR., MC, USN
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NAVREGMEDCEN, CHARLESTON, SC.	CO CAPT I.J. WOODSTEIN, MC, USN DCS CAPT W.L. BRANNON, JR., MC, USN DAS CDR G.M. ELLIS, MSC, USN CH NURSE CAPT M. YOUNG, NC, USN

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SPAIN	
U.S. NAVHOSP, ROTA	CO CAPT J.E. WILSON, MC, USN DSC CAPT A.R. PEARSON, MC, USN DAS CDR C.A. HARTMAN, MSC, USN CH NURSE CDR B. WEIDT, NC, USN

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SECOND MARINE DIVISION SURGEON	CAPT R.M. LEHMAN, MC, USN
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SECOND FORCE SERVICE SUPPORT GROUP	22ND DENCO FORTRPS CAPT J.S. KITZMILLER, DC, USN
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FIRST MARINE DIVISION	CAPT R.C. HODGES, MSC, USN
FIRST FORCE SERVICE SUPPORT GROUP	FIRST DENCO CAPT J.D. MAHONEY, DC, USN
FIRST MARINE AIRCRAFT WING	CAPT J.W. BROUGH, MC, USN
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FIRST MARINE BRIGADE	CDR M.O. ABBOTT, MC, USN 21ST DENCO CAPT L.M. MULDRON, JR., DC, USN AO LT LOCHHART, MSC, USN
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THIRD FORCE SERVICE SUPPORT GROUP	THIRD DENCO CAPT R.M. ROMANIELLO, DC, USN
THIRD MARINE AIRCRAFT WING	CAPT C.H. SPENCE, MC, USN (ADDU)
FIRST FORCE SERVICE SUPPORT GROUP	13TH DENCO CAPT R.E. WILLIAMS, JR., DC, USN
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U.S. NAVREGDENCEN, GUAM CO CAPT R.D. PRINCE, DC, USN
DCS CAPT H.C. DEATON, DC, USN
DAS LCDR O.H. GRISHAM, MSC, USN

COMNAVAMARIANAS CAPT R.D. PRINCE, DC, USN (ADDU)

CAIRO, EGYPT

U.S. NAVMEDRSCHUNIT 3, CO CAPT R.H. WATTEN, MC, USN
AO LCDR H. PETERSEN, MSC, USN
SR NURSE CDR S. ROSS, NC, USN

PHILIPPINES

U.S. NAVREGMEDCEN, SUBIC BAY, RP CO CAPT R.A. PROULX, MC, USN
DCS LCDR J.S. MILLER, JR., MC, USNR
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CH NURSE CDR J. KELLY, NC, USN

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NOTES & ANNOUNCEMENTS

IN MEMORIAM

John C. Lang, Ph.D., a management consultant and lecturer in the Executive Medicine Program and other Medical Department management courses at the Naval School of Health Sciences, Bethesda, Md., died 18 Sept 1979 at the age of 68.

Born in Delmont, S.D., Dr. Lang earned a bachelor's degree in chemistry and physics from Valley City State College in North Dakota and a master's degree in personnel administration from Northwestern University. He later graduated with a master's degree and a doctorate in administration and supervision from George Washington University.

Dr. Lang served with the U.S. Navy in World War II then joined the Bureau of Naval Personnel. As an authority on curriculum and personnel, he helped the governments of Greece and Turkey set up their naval training programs and served as a naval advisor to other countries, including Iran, Denmark, Spain, Portugal, and South Vietnam.

Since 1972, Dr. Lang had been a regular lecturer in Medical Department programs, participating in Prospective Commanding Officers' Conferences, Executive Medicine Programs, and the Health Care Administration Program. His presentations were characterized by the nicest blend of insights and humor, and were consistent highlights of the programs. He also had the unique ability to help the students analyze their leadership style and understand its effect in motivating others.

CAPT Wood G. van Valkenburgh, MC, USN, a Navy staff physician at the National Naval Medical Center, Bethesda, Md., died 21 Aug 1979 at age 46.

Dr. van Valkenburgh was born in East Orange, N.J., and graduated from the Virginia Polytechnic Institute and the Medical College of Virginia. He entered the Navy and served his internship at the National Naval Medical Center. He served at sea from 1960 to 1962 and then took further training in Philadelphia, Pa., and Richmond, Va. Dr. van Valkenburgh was a staff physician at NRMHC Portsmouth, Va., before returning to the National Naval Medical Center in 1970 as head of the rheumatology branch of the Internal Medicine Service. He also was an associate professor of medicine at the Uniformed Services University of the Health Sciences Medical School, Bethesda, Md.

Dr. van Valkenburgh was a diplomate of the American College of Physicians.

POSTDOCTORAL ASSOCIATESHIPS

Applications are now being accepted for the postdoctoral research associateship programs conducted by the National Research Council of the National Academy of Sciences on behalf of the Naval Medical Research and Development Command (NMRDC).

Under the programs, postdoctoral biomedical engineers and medical, biological, and behavioral scientists participate in biomedical research projects conducted in NMRDC laboratories. Awards, made on a competitive basis, are tenable at five Navy facilities: the Naval Medical Research Institute, Bethesda, Md.; the Naval Aerospace Medical Research Laboratory, Pensacola, Fla.; the Aircraft and Crew Systems Technology Directorate, Naval Air Development Command, Warminster, Pa.; the Naval Submarine Medical Research Laboratory, Groton, Conn.; and the Naval Health Research Center, San Diego, Calif.

Areas in which the research associateships are awarded are: experimental medicine, immunology, undersea medicine, aerospace medicine, behavioral sciences, biochemistry, biophysics, environmental stress, microbiology, parasitology, virology, biomagnetics, physiology, and radiation biology.

Candidates must hold an M.D., a D.D.S., or a Ph.D. degree or the equivalent, and must be research oriented.

The National Research Council screens the candidates' records, selects applicants, and approves the scientific merits of laboratory projects and the credentials of research advisors.

Applications must be postmarked no later than 15 Jan 1980 and must be received in the Council's Associateship Office no later than 25 Jan 1980. Supporting documents must be received by 11 Feb 1980.

For further details, write: Associateship Office (JH-608-NI), National Research Council, 2101 Constitution Ave., N.W., Washington, D.C. 20418.

OCCUPATIONAL HEALTH WORKSHOP

The 22nd Navy Occupational Health Workshop will be held 14-18 Jan 1980 at the U.S. Grant Hotel, San Diego, Calif.

The workshop is open to all occupational health professionals. There is no registration fee.

For further information, contact: Dianne Best or LT J. Moody, MSC, USN, Navy Environmental Health Center, Naval Station, Norfolk, Va. 23511. Telephone: Autovon 690-4657, Commercial (804) 444-4657.

PSYCHIATRY CLERKSHIPS

Psychiatry clerkships for third and fourth year medical students from the Uniformed Services University of the Health Sciences has been established at Parris Island, S.C., in conjunction with the Department of Psychiatry, Naval Hospital, Beaufort, S.C.

The clerkship is entitled, "Recruit Training: Psychiatric Aspects." Its general objective is to familiarize the medical student with the unique aspects of intensive Marine recruit training and to help the student develop familiarity and skill in assessing psychiatric maladaptation to the training experience and its management. It will provide the clerk with opportunities to study indications and decision making in the administrative discharge process.

The clerks will gain expertise in the evaluation of recruits referred from platoons for psychiatric assessment and help to view the recruit as undergoing a stressful, structured transition from late adolescence into early adulthood. The necessity of being aware of pre-enlistment personality formation as well as the physical, social, and psychological structure of the training depot and its personnel will be experienced. There will also be an experience in the evaluation and inservice training of drill instructors.

The clerkships will be four weeks in duration, limited to two students at a time, and offered any time during the academic year.

ADVANCE APPROVAL FOR RTC CARE

A new method by which service families can obtain advance information on whether CHAMPUS will share the cost of care for an emotionally disturbed child in a residential treatment center (RTC) has been announced by CHAMPUS officials.

Under the CHAMPUS Regulation, approval by OCHAMPUS is required before any care in an RTC can be cost-shared by CHAMPUS. There is no requirement, however, that such approval be obtained before treatment starts.

There is always the possibility that care obtained before approval by OCHAMPUS will be denied cost-sharing upon review. In this instance, the service family would have to pay the entire bill.

To avoid this, the new procedure permits the service family to obtain a review before the child's admission and to obtain an advance decision on whether CHAMPUS will cost-share the first 30 days. Under the previous procedure, no such review and decision were possible until the child had actually entered the RTC.

Any authorization for initial admission—whether it is granted before or after admission—will, generally, be

for a maximum of 30 days. The only condition under which the authorization period would be longer than 30 days is where the RTC has submitted a treatment plan which can be considered along with the request for initial authorization. If the initial evaluation indicates the patient needs extended RTC care, a request should be sent to OCHAMPUS as soon as possible by the RTC, but not later than 30 days after the initial admission.

Service families are encouraged to use the new procedure to protect themselves from incurring large bills for treatment which will not be cost-shared by CHAMPUS. Details of CHAMPUS benefits for RTC care and how to apply for them, including the information required to evaluate a request for either an initial admission or extended care, can be obtained from a CHAMPUS advisor or by writing to OCHAMPUS, Aurora, Colo. 80045.

INPATIENT MEDICAL CARE CHARGES INCREASED

The Defense Department announced that effective 1 Oct 1979, dependents of active duty, retired, and deceased servicemembers will be charged \$5 per day for inpatient care at Uniformed Services hospitals. The previous charge was \$4.65 per day.

New cost-share requirements went into effect on the same day for inpatient care received from civilian sources by spouses and children of active duty servicemembers under CHAMPUS. These individuals will pay \$5 per day, with a minimum cost-share requirement of \$25 if they are hospitalized for less than five days. Previously, they paid \$4.65 per day, with a minimum requirement of \$25.

By law, the inpatient cost-share requirement under CHAMPUS for spouses and children of active duty servicemembers is based on the charge at Uniformed Services hospitals.

The new rate does not apply to CHAMPUS cost-sharing of inpatient care for retirees or dependents of retired or deceased members. Individuals in these categories who are eligible for CHAMPUS pay 25 percent of the allowable medical facility charges and professional fees.

Inpatient charges at Uniformed Services hospitals are adjusted periodically to reflect changes in Uniformed Services pay. Previously, this adjustment was made at the start of a calendar year. Beginning last year, however, the adjustment was made at the start of the fiscal year.

The increase from \$4.65 per day to \$5 per day is approximately the same percentage increase as the pay raise that went into effect on 1 Oct 1979.

BUMED SITREP

TALC POWDRAGE

The association of malignant mesothelioma of the pleura with inhalation of asbestos dust particles is well recognized. During the 1930s insufflation of talc into the pleural space was used to create a chemical pleuritis in patients with recurrent pneumothorax. This practice reached its zenith during the 1940s and, perhaps, the early 1950s, and was replaced by other methodologies during the 1960s. Some forms of talcum powder may be contaminated with up to 85 percent asbestos fiber. Because of this, BUMED has initiated negotiations with the Veterans Follow-Up Agency, of the National Academy of Sciences, to follow a cohort of persons who had talc poufrage 15 to 35 years ago. The progress in identifying this cohort has been extremely slow and difficult. Individual thoracic surgeons, chest physicians, internists, and other primary care physicians, who have knowledge of *groups* of patients who can be identified as having been treated by talc poufrage, are asked to communicate the information in writing to CAPT R.L. Marlor, MC, USN, BUMED (MED 314). CAPT Marlor is also interested in obtaining samples of talcum powder such as that used for talc poufrage in earlier years for analysis of asbestos fiber content. Some of this material may still be found in the "bottom drawers" of surgical suites in some of our older hospitals. Samples, if noted, should be labeled and forwarded to MED 314, at the Bureau of Medicine and Surgery.

ENERGY CONSUMPTION BELOW 1975 BASELINE

For the third quarter of FY 79, BUMED energy consumption was 4.5 percent below the 1975 baseline. However, this is an increase of almost 2 percent over the same period during FY78. NAVHOSP PAXRIV and NRMCS at Charleston, Jacksonville, Newport, Long Beach, Philadelphia, and Yokosuka were significantly below their FY 75 baselines.

PREVENTIVE MEDICINE ACTIVITIES IN ASSOCIATION WITH HURRICANE DAVID

In response to requests from DOD, the Joint Chiefs of Staff, and the Department of State, CINCLANT/CINCLANTFLT was requested to lend assistance to Dominica and the Dominican Republic following the massive destruction wrought by Hurricane David. Preventive medicine personnel were required as members of Disaster Assistance Teams. In order to

meet this requirement and maintain fleet support, it was necessary to call upon additional preventive medicine personnel outside of the NAVENPVNTMEDUs. Personnel were dispatched from NAVENPVNTMEDU-2, Norfolk, Va., NAVENPVNTMEDU-5, San Diego, Calif., NAVREGMEDCEN Portsmouth, Va., NAV-AEROSPREGMEDCEN Pensacola, Fla., NAVREGMEDCEN Camp Lejeune, N.C., and the NAVENVIR-HLTHCEN Norfolk, Va. A Disease Vector Control Team from the Navy Disease Vector Ecology and Control Center, Jacksonville, Fla., deployed to the Dominican Republic and one from Navy Disease Vector Ecology and Control Center, Alameda, Calif., were dispatched to assist a Pan American Health Organization Team on the Island of Dominica.

EXECUTIVE MEDICINE CLASS NOMINATIONS AVAILABLE

The first FY 80 Executive Medicine Class began 15 Oct 1979. Some quotas are still available for classes convening 26 Nov 1979, 7 Jan 1980, and 28 Jan 1980. Medical Corps nominations should be submitted to Chief, Bureau of Medicine and Surgery (MED 21).

AGENT ORANGE UPDATE

Agent Orange was an herbicide aerially dispersed in Vietnam, containing a specific combination of 2, 4-D and 2, 4, 5-T as a potent toxin. A number of side effects, including carcinogenesis, teratogenesis, and the like, have been alleged to be associated with exposure to Agent Orange toxicants. A primary sign of acute exposure to Agent Orange was chloracne. This dermatologic condition was so common a sequelae to exposure, that its absence by history in a patient alleging Agent Orange exposure makes it unlikely that exposure occurred. Most Agent Orange exposures in active duty personnel occurred in the Air Force where the material was handled, transferred, and sprayed over broad areas. Ground exposure was less likely, since it took approximately 6 weeks for defoliation to take place. BUMED (MED 31412) is attempting to identify any coincidental exposure among Navy and Marine Corps personnel, and would be interested in verified or anecdotal information on Marine Corps personnel, Seabees, or crews of riverine patrol boats, who may have actually handled or sprayed Agent Orange material. Write or call CDR R.V. Peterson, MSC, USN, BUMED (Med 31412), Autovon 294-4384, Commercial (202) 254-4384.

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